

00-01155

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 09447

REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | 2a. DATE OF DEATH   |  | 2b. HOUR  |  |
|   |  | FIRST MIDDLE LAST<br>Javita L Cannon  |  | MONTH DAY YEAR<br>3 21 86   |  | 10 <sup>07</sup> PM   |  |
| 3. SEX<br>F   |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  |
|   |  |   |  | MONTH DAY YEAR<br>06 29 13  |  | 72 YRS  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |
| MD  |  | USA   |  |   |  | Somerset County MD  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| Princess Anne   |  | Marchin Manor Retirement Center   |  | Housewife   |  |   |  |
| 13a. STATE  |  |   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  |
| MD  |  |   |  | Wicomico  |  | Salisbury   |  |
| 14. FATHER'S NAME<br>(FIRST MIDDLE LAST)  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>(FIRST MIDDLE LAST)   |  |   |  |
| Andrew W Wright   |  |   |  | Anderson  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATE)  |  | 17. INFORMANT ADDRESS   |  |   |  |
|   |  | 019-03-1767   |  |   |  |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Organic Brain Syndrome</u>  |  |   |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>Immediate</u><br><u>Days</u><br><u>Years</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes</u>  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> HAD WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>85</u> , to <u>21 March</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>21 March</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><u>William A. Godfrey</u>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br><u>3/22/86</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>William A. Godfrey</u>  |  |   |  | 22e. ADDRESS<br><u>P.O. Box 40 Princess Anne, Md 21853</u>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |
| B   |  | 3-25-86   |  | Mt Calvary Cemetery   |  | Fruitland Wic MD  |  |
| 24. FUNERAL DIRECTOR<br>NAME <u>Folsz 7/4 Salisbury</u> ADDRESS   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><u>MAR 24 1986</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>L. F. Anderson-Randall</u>   |  |

20% COLLOID FIBERS

00-00775

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |   |   |  |  |  |  |  |  |
|---|---|---|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |   |   | 2a. DATE OF DEATH  |  |  | 2b. HOUR   |  |  |
| FIRST MIDDLE LAST<br>Wade Hampton Cullen  |   |   | MONTH DAY YEAR<br>3 11 86  |  |  | 12:25P <sub>M</sub>  |  |  |
| 3. SEX  | 4. RACE   | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |  | 7. IF UNDER 1 YEAR   |  |  |
| Male  | White   | MONTH DAY YEAR<br>Jan. 6 1904   | 82 YRS   |  |  | MONTHS DAYS HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  |  |  |
| Maryland  | USA   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Somerset MD   |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  |  | 12b. KIND OF BUSINESS OR INDUSTRY          |  |
| Crisfield   | Alice Byrd Tawes Nursing Home   |   |  | Farmer   |  |  | Farming                                    |  |
| 13a. STATE  |   |   | 13b. COUNTY  |  |  | 13c. CITY OR TOWN  |  |  |
| MD  |   |   | Somerset   |  |  | Crisfield  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                          |  |  |  |  |  |
| Wade H. Cullen  |   |   | Ola Marie Garrison   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |   |   | 16b. SOCIAL SECURITY NO.   |  |  | 17. INFORMANT ADDRESS  |  |  |
| No  |   |   | 213-18-4256  |  |  | Elmer N. Cullen - same as 13 abcde   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute MI</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |   |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>10 min         |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes Mellitus; Hypertension</u>   |   |   |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|   |   |   |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |
|   |   |   |  |  |  |  |  |  |
| 22a. I certify that (1) this hospital attended the deceased from <u>3-11-86</u> to <u>3-11-86</u> , that (1) we lost saw the death occur on <u>3-11-86</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (If not, did not view the body after death.)                             |   |   |  |  |  |  |  |  |
| 23a. SIGNATURE<br><u>James A. Sterling, M.D.</u>  |   |   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>3/11/86                                    |
| 23b. PHYSICIAN'S NAME (TYPE OR PRINT)<br>James A. Sterling, M.D.  |   |   |  |  |  | 22d. ADDRESS<br>320 W. Main St. - Crisfield, MD 21817  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |   |   | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |
| Burial  |   |   | 3/13/86  |  | Sunnyridge Cemetery  |  | Crisfield - Somerset - MD                  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Bradshaw & Sons - Crisfield, MD 21817   |   |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 17 1986   |  |  |

MEDICAL CERTIFICATION

99

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of page 1.

Figure 2.

2001

[illegible]

1992

610

100-41730-1

STARS OF

00-00632

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send pages 1 and 2 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other terminal event, the medical examiner must be notified *immediately*.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |   |   |  |   |  |  |  |
|---|--|---|---|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |   |   | REG. NO.   |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Madge J. Harrison</b>   |  |   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>3-16-86</b> |   |  | 2b. HOUR<br><b>4:26a</b> M   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Oct. 13 1897</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b> YRS.   |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Somerset</b> MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Crisfield</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Edw. W. McCready Memorial Hospital</b> |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>At home</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>Somerset</b>  |   | 13c. CITY OR TOWN<br><b>Crisfield</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                 |  | 13e. STREET ADDRESS<br><b>432 Charlotte Ave./ 21817</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>George Poe</b>  |  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Mary Ellen Potter</b>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>  |  |   |   | 16b. SOCIAL SECURITY NO.<br><b>214-32-1546</b>  |  | 17. INFORMANT ADDRESS<br><b>Beatrice Headley - 434 Charlotte Ave.</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio-respiratory arrest</b>   |  |   |   |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CHF secondary to ASHD.</b>   |  |   |   |   |  |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |   |   |   |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Pneumonia.</b>   |  |   |   |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>3/9</b> 19 <b>86</b> to <b>3/16</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |   |  |   |  |  |  |
| 27b. SIGNATURE<br><i>[Signature]</i>  |  |   |   |   |  | DEGREE  |  | 27c. DATE SIGNED   |  |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Jesus Evangelista</b>   |  |   |   |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  |
| 27e. ADDRESS<br><b>Main St., Crisfield, Md. 21817</b>   |  |   |   |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>3/18/86</b>   |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sunnyridge Cemetery</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Crisfield - Somerset - MD</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>Bradshaw Funeral Home, Crisfield, Md. 21817</b>  |  |   |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 18 1986</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

066232

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

09450

|   |  |   |   |   |  |  |  |  |  |
|---|--|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(Type or print) First Middle Last<br><b>CURTIS L. LANDON</b>  |  |   | 2a. DATE OF DEATH<br>Month Day Year<br><b>March 2, 1986</b>       |   |  | 2b. HOUR a<br><b>4:50 M</b>  |  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br><b>August 16, 1912</b>  |  | 6. AGE (In years last birthday)<br><b>73</b> YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                                       |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S. A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Somerset County</b> Md.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Crisfield</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>McCready Memorial Hospital</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Dough Mixer</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Baking</b>   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Somerset</b>  |   | 13c. CITY OR TOWN<br><b>Crisfield</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>117 Maple St. (21817)</b>   |  |
| 14. FATHER'S NAME First Middle Last<br><b>Curtis M. Landon</b>  |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Fannie Parks</b> |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>Yes</b>  |  | (If yes give war or dates of service)<br><b>W. W. II</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>223-26-0684</b>  |  | 17. INFORMANT Address<br><b>Beulah E. Landon Same as 13 a, b, c, d, e</b>                    |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute respiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Aspiration of gastric contents</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Acute aortic dissection</b> |  |   |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 min</b><br><b>20 min</b><br><b>12 hours</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/><br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                      |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10</b> , 19 <b>80</b> , to <b>3/2</b> , 19 <b>86</b> , that (I) (we) (last) saw the deceased alive on <b>3-2</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>James A. Sterling, M.D.</b>  |  | 22c. DATE SIGNED<br><b>3/3/86</b>   |   | 22d. PHYSICIAN'S NAME (Type)<br><b>James A. Sterling, M.D.</b>  |  |  |  |  |  |
| 22e. ADDRESS<br><b>320 W. Main St. - Crisfield, Md. 21817</b>   |  |   |   |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>3/5/86</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>American Legion Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Crisfield Somerset Md.</b>               |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Bradshaw &amp; Sons</b>  |  | ADDRESS<br><b>Crisfield, Md. 21817</b>  |   | 25a. REC'D BY REGISTRAR<br>DATE <b>MAR 5 1986</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John A. ...</b>   |  |  |  |



00-02161

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. CONTAIN PAGE 3 FOR YOUR FILES TO FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

09451

|   |         |                                    |  |                                  |                                   |  |  |                     |  |                                      |  |  |  |          |  |
|---|---------|------------------------------------|--|----------------------------------|-----------------------------------|--|--|---------------------|--|--------------------------------------|--|--|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         |                                    | FIRST MIDDLE LAST  |                                  |                                   | 2a. DATE KNOWN OF DEATH ESTI- MATED  |  |                     |  | MONTH DAY YEAR                       |  |  |  | 2b. HOUR |  |
| Margie  |         |                                    | Long   |                                  |                                   | 3-26-1986  |  |                     |  | 8 AM                                 |  |  |  |          |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH<br>MONTH DAY YEAR | 6. AGE (IN YEARS<br>LAST BIRTHDAY)   | 7. IF UNDER 1 YR.<br>MONTHS DAYS | 8. IF UNDER 24 HRS.<br>HOURS MIN. | 2c. DATE PRONOUNCED DEAD   |  |                     |  | MONTH DAY YEAR                       |  |  |  | 2d. HOUR |  |
| Female  | Blk.    | 3-23-09                            | 76 YRS.  |                                  |                                   | 3-26-1986  |  |                     |  | 8A M                                 |  |  |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         |                                    | 7b. CITIZEN OF WHAT COUNTRY?   |                                  |                                   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                     |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |  |  | MD.      |  |
| Maryland  |         |                                    | USA  |                                  |                                   |  |  |                     |  | Somerset                             |  |  |  |          |  |
| 10. CITY OR TOWN OF DEATH   |         |                                    | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                  |                                   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |                     |  | 12b. KIND OF BUSINESS OR INDUSTRY    |  |  |  |          |  |
| Pocomoke  |         |                                    | Home   |                                  |                                   | Domestic   |  |                     |  | Housework                            |  |  |  |          |  |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |         |                                    |  |                                  |                                   | 13b. INSIDE CITY LIMITS?   |  | 13c. STREET ADDRESS |  |                                      |  |  |  |          |  |
| Md. Somerset  |         |                                    |  |                                  |                                   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | RFD 21851           |  |                                      |  |  |  |          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |         |                                    |  |                                  |                                   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |  |                     |  |                                      |  |  |  |          |  |
| John Wesley Johnson   |         |                                    |  |                                  |                                   | Mary Martin  |  |                     |  |                                      |  |  |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |         |                                    | 16b. SOCIAL SECURITY NO.   |                                  |                                   | 17. INFORMANT  |  |                     |  | ADDRESS                              |  |  |  |          |  |
| no  |         |                                    | 219-03-3672  |                                  |                                   | Esther Collier   |  |                     |  | Pocomoke, Md.                        |  |  |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Pul Edema</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>Acute MI</u><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <u>Hypertensive C-V disease</u><br>(b) <u>4h</u><br>(c) <u>1 hr</u><br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |         |                                    |  |                                  |                                   |  |  |                     |  |                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |          |  |
|   |         |                                    |  |                                  |                                   |  |  |                     |  |                                      |  | 1 hr   |  |          |  |
|   |         |                                    |  |                                  |                                   |  |  |                     |  |                                      |  | 4h   |  |          |  |
|   |         |                                    |  |                                  |                                   |  |  |                     |  |                                      |  | 1 year                                       |  |          |  |
| 19a. DATE OF OPERATION  |         |                                    | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                                  |                                   |  |  |                     |  |                                      |  |  | 20. AUTOPSY?   |          |  |
|   |         |                                    |  |                                  |                                   |  |  |                     |  |                                      |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         |                                    | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR  |                                  |                                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |                     |  |                                      |  |  |  |          |  |
|   |         |                                    | P.M. 19  |                                  |                                   |  |  |                     |  |                                      |  |  |  |          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |         |                                    | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |                                  |                                   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |                     |  |                                      |  |  |  |          |  |
|   |         |                                    |  |                                  |                                   |  |  |                     |  |                                      |  |  |  |          |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion   |         |                                    |  |                                  |                                   |  |  |                     |  |                                      |  |  |  |          |  |
| TITLE (SPECIFY)   |         |                                    |  |                                  |                                   |  |  |                     |  |                                      |  |  |  |          |  |
| ACTUAL SIGNATURE  |         |                                    | M.D.   |                                  |                                   | MEDICAL EXAMINER   |  |                     | DATE SIGNED                                |                                      |  |  |  |          |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)  |         |                                    | ADDRESS  |                                  |                                   |  |  |                     |  |                                      |  |  |  |          |  |
| DAMES A. STERLING   |         |                                    | CRISFIELD, MD 21817  |                                  |                                   |  |  |                     |  |                                      |  |  |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |         |                                    | 23b. DATE  |                                  |                                   | 23c. NAME OF CEMETERY OR CREMATORY   |  |                     | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |                                      |  |  |  |          |  |
| Burial  |         |                                    | 3-30-86  |                                  |                                   | Tinsley Memorial   |  |                     | Pocomoke Somerset, Md.                     |                                      |  |  |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME  |         |                                    | ADDRESS  |                                  |                                   | 25a. DATE REC'D. BY REGISTRAR  |  |                     | 25b. REGISTRAR'S SIGNATURE                 |                                      |  |  |  |          |  |
| Keith Wharton   |         |                                    | Accomac, Va 22301  |                                  |                                   | APR 02 1986  |  |                     | John Davidson-Randall                      |                                      |  |  |  |          |  |

BP  
DHMH - 17  
(VR A15 ME (5))  
15M7/77



Esther College -



00-01200

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

6 0 9 4 5 2

|  |  |   |  |   |                             |   |  |
|--|--|---|--|---|-----------------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>William Francis Moore</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>3/16/86</b> |   | 2b. HOUR<br><b>12:15 AM</b> |   |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>NEGRO</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>9 27 10</b>   |                             | 6. AGE (IN YEARS LAST BIRTHDAY) YRS<br><b>75</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Somerset</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Princess Anne</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MANOKIN MANOR NURSING HOME</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>laborer</b>   |                             | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Poultry</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY<br><b>MARYLAND WORCESTER</b>   |  | 13c. CITY OR TOWN<br><b>BERLIN</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                             | 13e. STREET ADDRESS / ZIP CODE<br><b>Rt. #3, Box 335/21811</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>ISAAC MOORE</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>ANNIE MASSEY</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)<br><b>NO</b>   |                             | 16b. SOCIAL SECURITY NO.<br><b>222-05-2288</b>  |  |
| 17. INFORMANT<br><b>MARY I. MOORE</b>  |  | 18. ADDRESS<br><b>SAME AS ABOVE</b>   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>CVA.</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>DIABETES.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b>   |  |   |  |   |                             |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                             | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19 85</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                             |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |                             |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4-23</b> 19 <b>85</b> , to <b>3-16</b> 19 <b>85</b> , that (I) (we) lost saw the deceased alive on <b>3-15</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |                             |   |  |
| 22b. SIGNATURE<br><b>Charles Stegman</b>   |  | DEGREE <b>MD</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |                             | 22c. DATE SIGNED<br><b>3-16-86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>C Stegman MD</b>   |  | 22e. ADDRESS<br><b>POB 40 Princess Anne Md 21853</b>  |  |   |                             |   |  |
| 23a. BURIAL CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>3/20/86</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>TREE AME CEMETERY</b>  |                             | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BERLIN WORCESTER MD</b>   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>JOEY MEMORIAL CHAPEL</b>   |  | ADDRESS<br><b>SALISBURY, MD</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 24 1986</b>   |                             | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson</b>  |  |

MEDICAL CERTIFICATION



NOV 10 1960  
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OF THE  
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DEPARTMENT OF  
COMMERCE  
WASHINGTON, D.C.

00-00022

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH09453  
REG. NO.

|   |                         |   |  |   |  |   |   |   |  |
|---|-------------------------|---|--|---|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>F. ROBERT STEWART</b>   |                         |   |  | 2a. DATE KNOWN OF DEATH<br><input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR<br><b>Mar. 9, 1986</b>      |  |   |   | 2b. HOUR<br><b>6:45 a.m.</b>  |  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan. 19, 1922</b>  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br><b>64 YRS.</b> | IF UNDER 1 YR.<br>MONTHS DAYS   | IF UNDER 24 HRS.<br>HOURS MIN.   | 7c. DATE PRONOUNCED DEAD<br><b>Mar. 9, 1986</b>   |   | 7d. HOUR<br><b>9:45 a.m.</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>West Virginia</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Somerset County</b> MD.  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Crisfield</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>McCready Memorial Hospital</b> |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Employee</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Cutlery</b> |   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |                         |   |  |   |  |   |   |   |  |
| 13a. STATE<br><b>Maryland</b>   |                         | 13b. COUNTY<br><b>Somerset</b>  |  | 13c. CITY OR TOWN<br><b>Crisfield</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS<br><b>14 Pear St. (21817)</b> |   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Roy C. Stewart</b>   |                         |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mabel Cork</b>  |  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>Yes</b>   |                         | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>W. W. II</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>June Dize Stewart Same as 13 a,b,c,d,e</b>   |  |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute M. I.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |                         |   |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Instant</b>                      |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |                         |   |  |   |  |   |   |   |  |
| 19a. DATE OF OPERATION  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                         |   |  |   |  |   |   |   |  |
| ACTUAL SIGNATURE<br><i>James A. Sterling</i>  |                         | EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>James A. Sterling, M.D.</b>  |  | TITLE (SPECIFY)<br><b>Deputy</b>  |  | MEDICAL EXAMINER  |   | DATE SIGNED<br><b>3/10/86</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |                         | 23b. DATE<br><b>3/12/86</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>American Legion Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Crisfield Somerset Md.</b>   |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Bradshaw &amp; Sons</b>  |                         |   |  | ADDRESS<br><b>Crisfield, Md. 21817</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 12 1986</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><i>James Davidson</i>                                 |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE DEER WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82



00-00812

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |                              |   |   |  |   |  |
|--|--|---|--|---|------------------------------|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Dorothy I. Wheatley                 |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3-11-86                         |   |                              | 2b. HOUR<br>11:02 AM  |   |  |   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>March 15, 1900  |                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS.                                    |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Somerset MD.                          |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Crisfield                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Edw. W. McCready Mem. Hospital |  |   |                              | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>At Home |   |  |
| 13a. STATE<br>Va.  |  |   | 13b. COUNTY<br>Accomack  |   | 13c. CITY OR TOWN<br>Tangier |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>Box 14 / 23440-99999 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William G. Smith                 |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elverta Dise          |   |                              |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>231-42-8371 |   |                              | 17. INFORMANT<br>ADDRESS<br>Mrs. Bertie Parks - same as 13 abode              |   |  |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Massive Cerebral Infarct.

DUE TO, OR AS A CONSEQUENCE OF

(b) Embolic CVA.

DUE TO, OR AS A CONSEQUENCE OF

(c) Atrial fibrillation

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/26/1980, to 3/11/1986, that (I/we) lost<br>saw the deceased alive on 3/11/86, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br>Dr. Christjon Huddleston   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Christjon Huddleston  |  |  |  | 22e. ADDRESS<br>25 Broad St., Princess Anne, Md. 21853  |  |   |  |

|   |  |                      |  |   |  |   |  |
|---|--|----------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                |  | 23b. DATE<br>3/14/86 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Wheatley Cemetery |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Tangier - Accomack - VA |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Bradshaw & Sons, Crisfield, Md. 21817 |  |                      |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 17 1986            |  | 25b. REGISTRAR'S SIGNATURE<br>C. Fisher                               |  |

DHMM - 16 50M 4/82  
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of course.

March 18, 1960  
Box 14, 2000  
Date

Box 14, 2000

Box 14, 2000



00-02475

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |   |  |   |  |  |  |   |  |
|--|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><i>Howard W. Whittington</i>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>3/24/86</i>                  |   |  | 2b. HOUR<br><i>1 P.M.</i>  |  |   |  |
| 3. SEX<br><i>M</i>   |  | 4. RACE<br><i>B</i>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>6 5 1905</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>80</i>                                       |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><i>Md</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.</i>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>SOMERSKT</i> MD.                        |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Upper Hill</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>AT HOME</i> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Laborer</i> |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE <i>Md</i> 13b. COUNTY <i>Som.</i> 13c. CITY OR TOWN <i>Upper Hill</i> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS <i>P.O. Box 263 21868</i>  |  |   |  |   |  |  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>William H. Whittington</i>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Maggie Coolbourne</i>  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>  |  |   | 16b. SOCIAL SECURITY NO.<br><i>219-05-7336</i>                         |   | 17. INFORMANT<br>ADDRESS<br><i>Mary L. Whittington-Upper Hill</i>  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Inanition</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>          |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <i>19</i>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (II) (we) lost<br>saw the deceased alive on <i>3/4/86</i> , 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><i>J. A. Cockey</i> DEGREE <i>MD</i>   |  |   |  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  | 22c. DATE SIGNED<br><i>3/24/86</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>J. A. Cockey</i>   |  |   |  |   | 22e. ADDRESS<br><i>218 NEWTON ST. SALISBURY MD 21801</i>   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>  |  |   | 23b. DATE<br><i>3/29/86</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Upper Hill</i>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Upper Hill Som Md</i> |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>Anthony E. Ward Criggle, MD.</i>  |  |   |  |   | 25a. DATE RECEIVED BY REGISTRAR<br><i>APR 03 1986</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                       |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

